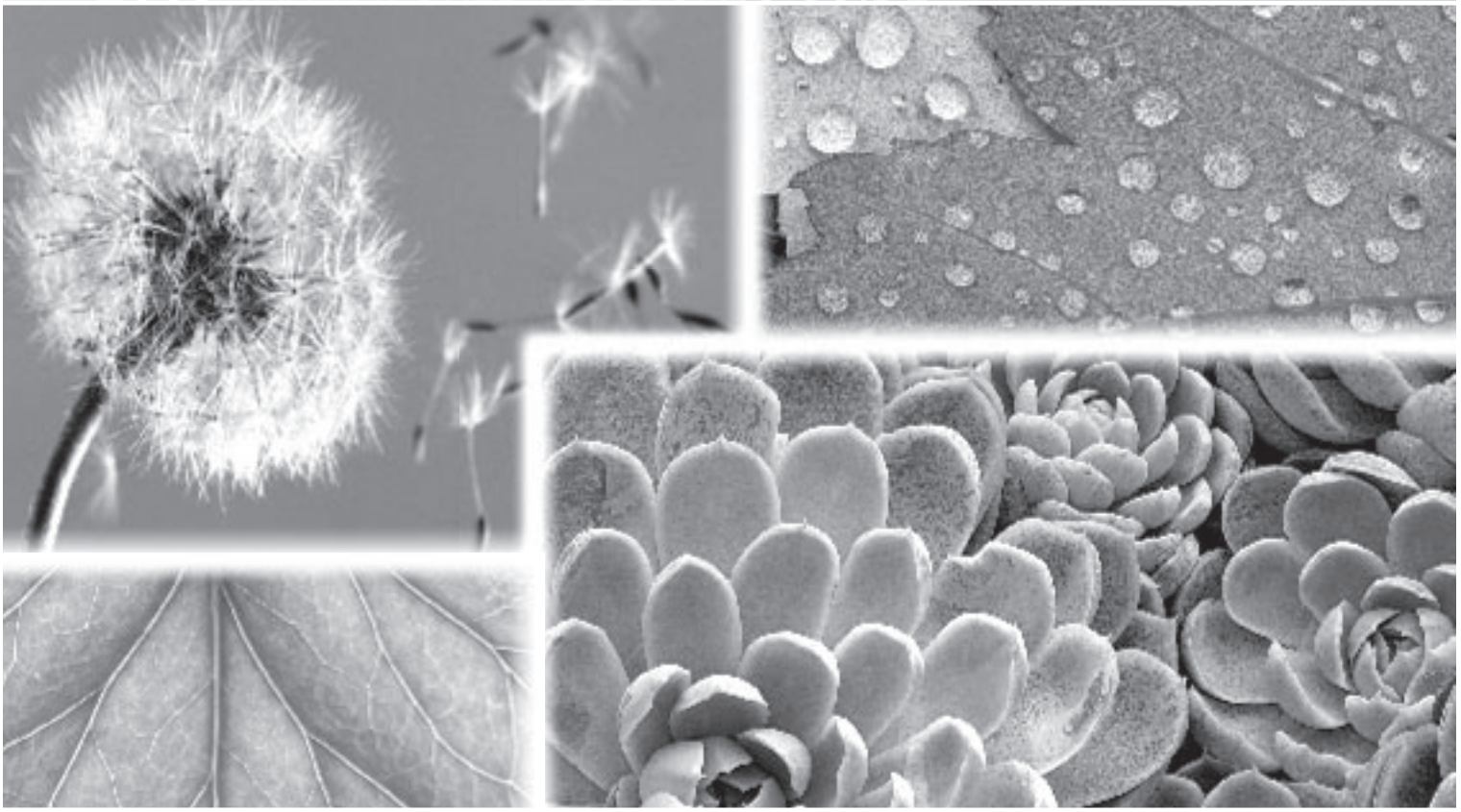
2005 TAX-FAVORED ACCOUNTS GUIDE



Value Life's Benefits

Employee Insurance Program
South Carolina Budget & Control Board

MONEYPLU$

Employee Benefits Resource Directory

COMPANY	DEPARTMENT	HOURS	PHONE /WEB ADDRESS
Fringe Benefits Management Company (Flexible Spending Accounts, Health Savings Accounts)	FBMC Customer Service	M - F, 7 a.m. - 10 p.m.	1-800-342-8017
	Automated Services	24 hours a day	1-800-865-3262
			www.fbmc-benefits.com

Table of Contents

IMPORTANT DATES TO REMEMBER

Your Annual Enrollment dates are:
October 1, 2004, through October 31, 2004.

Your Period of Coverage dates are:
January 1, 2005, through December 31, 2005.

What's New

- MONEYPLU$ now offers you a Health Savings Account (HSA) in conjunction with a high deductible health plan, the State Health Plan Savings Plan.
- If you choose to enroll in an HSA, a MONEYPLU$ limited-use Medical Spending Account will be available to you.
- MONEYPLU$ participants will be able to choose the EZ REIMBURSE® MasterCard® Card for reimbursement of eligible medical expenses through the MONEYPLU$ Medical Spending Account (but not the limited-use Medical Spending Account).

How do I enroll?

You are automatically enrolled in the MONEYPLU$ Pretax Group Premium Feature. If you choose not to participate in this feature, you must indicate so on your Notice of Election (NOE) form. If you want to participate in the **Medical Spending** or **Dependent Care Account**, you must complete an Enrollment Form during the enrollment period, which is October 1 through 31, or within 31 days of a change in status. You will receive a confirmation of this enrollment in December. Please review this for accuracy, and advise FBMC of any discrepancies. This confirmation package will also contain a Direct Deposit Form. If you enroll in the SHP Savings Plan, you may also enroll in a **Health Savings Account** during Annual Enrollment, as well as at the start of any plan year for coverage of future expenses.

Important Enrollment Information

- Annual Enrollment is October 1, 2004, through October 31, 2004.
- Your 2005 Plan Year is January 1, 2005, through December 31, 2005.
- Complete an Enrollment Form by October 31, 2004, to make changes to your current benefits.
- Return your completed Enrollment Form to your benefits administrator by **October 31, 2004**.
- Remember to bring all necessary dependent and beneficiary information to your enrollment session.
- If you choose to receive the EZ REIMBURSE® MasterCard® Card by checking the appropriate box on your Enrollment Form, a $20 non-refundable annual fee will be deducted from your MONEYPLU$ Medical Spending Account at the start of the plan year.
- You may visit FBMC's Web site at **www.fbmc-benefits.com** or e-mail **webcustomerservice@fbmc-benefits.com** for more information. You may also contact FBMC Customer Service at 1-800-342-8017.

Making Your Benefits Work for You — It's Easy.

- Once you review the Spending Account guidelines and become familiar with how the program works, you'll determine how the program can save you and your family a significant amount of tax money — if you're clear on the governing IRS rules. Refer to Page 6 for Spending Account guidelines.
- Submit your supporting documentation and completed reimbursement request form (for paper claims) to FBMC for reimbursement processing. Once the plan year ends, you have a 90-day grace period to submit your supporting documentation.
- Remember to submit your supporting receipts, billing statements or invoices, along with your EZ REIMBURSE® Card Transmittal Sheet, for "Outstanding Debit Card Transactions" appearing on your Monthly Statement when using your EZ REIMBURSE® MasterCard® Card.

Getting Answers

TO YOUR QUESTIONS

Getting answers to many of your benefit questions is now easier than ever. FBMC Customer Service offers you a variety of resources to make inquiries on your MONEYPLU$ Spending Account, including information from the FBMC Web site, Interactive Voice Response system or Customer Service.

FBMC Web Site

FBMC's Web site provides information regarding your benefits and comprehensive details on your MONEYPLU$ Spending Account(s).

By entering **www.fbmc-benefits.com** into your Internet browser, you will open FBMC's homepage. Answers to many of your benefit questions can be obtained by using the following navigational tabs located along the top portion of the home page.

Account Information

When you select the '**Account Information**' tab, you'll be prompted to enter your Social Security number and Personal Identification Number (PIN). After this login, the following menu items will be available to you.

- **My Benefits–** includes information on current benefits, such as effective date, number of deductions and pre-tax annual contribution
- **My Account Transactions–** allows review of transactions from your current and previous plan years, including grace period information
- **Account Balance–** gives specifics about account availability, paid amounts and payment status
- **My Claims–** provides information on open and current reimbursement claims such as date received, status and amount authorized
- **Change In Status–** enables confirmation of request status, date received and effective date
- **EZ REIMBURSE® MasterCard® Card Pharmacy Locator–** locate a participating pharmacy in your area
- **Tax Savings Analysis–** calculates potential per-pay-period and annual tax savings as well as long-term savings (no login required)

Downloading Forms

When you select the '**Download Forms**' tab, a choice of forms, including a Letter of Medical Need, FSA Reimbursement Request Claim Form, EZ REIMBURSE® Card Transmittal Sheet and Direct Deposit Form, are posted for your convenience.

Frequently Asked Questions

The '**Frequently Asked Questions**' tab provides answers to many of your general questions regarding MONEYPLU$ Spending Accounts, the EZ REIMBURSE® Card and enrollment information.

FBMC Customer Service

The '**Customer Service**' tab gives you a direct link to the FBMC Customer Service Center.

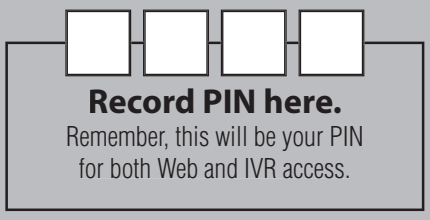
FBMC Interactive Benefits

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)

To access both the FBMC Web site and the Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN, whether using the Web site or the IVR system. After your initial login, select your own confidential four-digit PIN to access both systems in the future. Your new PIN cannot be the last four digits of your SSN, as it was previously. If you forget your PIN, you may send an e-mail to a Customer Service Representative at **webcustomerservice@fbmc-benefits.com**. Once you've selected your new PIN, you may access information about your benefits.



Record PIN here.
Remember, this will be your PIN for both Web and IVR access.

Note: Please be sure to keep this Tax-Favored Accounts Guide in a safe, convenient place, and refer to it for benefit information.

Who is eligible?

You must be a full-time, permanent employee and must be **eligible for state group insurance benefits** to participate in MONEYPLU$. However, you are not required to be enrolled in an insurance program in order to participate in MONEYPLU$. Retirees are not eligible to participate in MONEYPLU$.

Health Savings Account Eligibility

To participate in a **Health Savings Account**, you:

- must be covered by a high-deductible health plan, such as the State Health Plan Savings Plan available January 1, 2005.
- cannot be covered by any other health plan, including Medicare (you may be covered for specific injuries, accidents, disability, dental care, vision care and long-term care) and
- cannot be claimed as a dependent on another person's tax return.

Medical Spending Account Eligibility

To participate in a **Medical Spending Account**, you must have completed one year of continuous state service by January 1 following an enrollment period. You must re-enroll each year during the enrollment period, October 1 through October 31, for any changes that will be effective the following January 1. If you elect to participate in the new Health Savings Account, please remember that you will only be allowed to enroll in a MONEYPLU$ limited-use Medical Spending Account, for eligible vision and dental expenses. See Page 8 for more information.

Dependent Care Spending Account Eligibility

You can enroll in a **Dependent Care Spending Account** within 31 days of the date you are hired. If you do not enroll at that time, you can only enroll during the enrollment period, October 1 through October 31. You must re-enroll during each enrollment period to continue your account each plan year. Dependent Care Spending Accounts are available to you if you also participate in the new Health Savings Account.

You can also enroll in or make changes to your Spending Account(s) within 31 days of a change in family status. Changes during the year must be necessary and appropriate. All changes must be approved. (See the *Changing Your Coverage* section beginning on Page 18 for rules governing valid changes in status). To learn more about MONEYPLU$ Spending Accounts, see Page 6.

Pretax Group Insurance Premium Feature Eligibility

If you pay a health, dental or optional life premium, you are automatically enrolled on your Notice of Election (NOE) form in the **PreTax Group Premium Feature**, unless you decline. If you decline to participate in the **PreTax Group Premium Feature**, you can still enroll in it during the enrollment period, October 1 through October 31, or within 31 days of a change in family status as defined on Page 18. If you enroll during the enrollment period, your benefit will become effective January 1 of the next benefits year.

How does termination or leave affect my Spending Account?

If you terminate employment or go on unpaid leave, your eligibility for either or both Spending Accounts may change. While your Dependent Care Spending Account cannot be continued following termination or the start of unpaid leave, you may be able to change or continue your Medical Spending Account election upon completion of the appropriate forms and requirements. To make this change or to continue coverage, contact FBMC Customer Service within 30 days of the event by e-mail at **webcustomerservice@fbmc-benefits.com**, or by calling 1-800-342-8017.

Specific guidelines about your employer's termination and leave policies can be obtained from your employer. In addition, the Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact your employer for further information.

Appeal Process

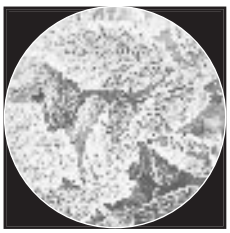
If you have a request for a mid-plan year election change, MONEYPLU$ reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to Fringe Benefits Management Company.

Your appeal must state:

- the name of your employer
- the date of the services for which your request was denied
- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

You must be eligible for state group insurance benefits to participate in MONEYPLU$. However, you are not required to be enrolled in an insurance program in order to participate in MONEYPLU$.



What is MONEYPLU$?

MONEYPLU$, administered by Fringe Benefits Management Company (FBMC), is a tax-favored account program made available through Internal Revenue Service (IRS) Code Sections 105, 125, 129 and 223 to stretch your medical expense and dependent care dollars. With MONEYPLU$, you elect to contribute an annual amount from your salary to be deducted pretax from your paycheck to pay for your eligible medical and dependent care expenses. As you incur eligible expenses during the plan year, you request reimbursement and get your money back fast!

MONEYPLU$ features include:

- **Health Savings Accounts**, as described in the *Health Savings Accounts* section, beginning on Page 8.

- a **Pre-Tax Group Insurance Premium** feature, allowing you to pay your State Health Plan, HMO, State Dental Plan, Dental Plus and Optional Life premiums with pre-tax dollars

Spending Accounts

- **Medical Spending Accounts**, allowing you to pay for eligible medical expenses with pre-tax dollars and

- **Dependent Care Accounts**, allowing you to pay for eligible dependent care expenses with pre-tax dollars

Is a Spending Account right for me?

If you can estimate eligible expenses during your plan year, you may save money by paying for them with a Spending Account. A portion of your salary is deposited into your Spending Account each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses with tax-free dollars.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis at **www.fbmc-benefits.com/customer/taxanalysis.asp**.

Receiving Reimbursement

Your Spending Accounts reimbursements will be processed within five business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Forms. To avoid delays, follow the instructions for submitting your requests located in the materials you will receive following enrollment. You may also elect to receive an EZ REIMBURSE® MasterCard® Card to electronically debits funds from your MONEYPLU$ Medical Spending Account. See Page 11 for more information.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- Spending Account reimbursement funds are automatically deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement. You will receive notification that the claim has been processed.

To apply, complete the Enrollment Form available from your confirmation package, benefits administrator, **www.fbmc-benefits.com** or call FBMC Customer Service at 1-800-342-8017. If you are currently enrolled in Direct Deposit, you do not need to re-enroll. Please note that processing your Direct Deposit enrollment may take between four to six weeks.

What types of Spending Accounts are available?

Your employer offers you a Medical Spending Account as well as a Dependent Care Spending Account. If you incur both types of expenses during a plan year, you can establish both types of Spending Accounts.

Medical Spending Accounts

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Medical Spending Account, including:

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-Counter items.

Remember, if you enroll in an HSA, you can also enroll in a limited-use Medical Spending Account to pay for eligible dental and vision expenses. For more information on a limited-use Medical Spending Account, refer to the *MONEYPLU$ Medical Spending Account* section on Page 9 and 12.

Dependent Care Spending Accounts

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- day care services
- in-home care
- nursery and preschool and
- summer day camps.

How MONEYPLU$ Spending Accounts Work

- Estimate carefully the annual amount you will spend for dependent care, eligible medical expenses and group insurance premiums.
- The annual amounts you elect to have deducted pretax from your paycheck will be divided into equal installments, deducted from your paycheck, then credited to your MONEYPLU$ accounts.
- After you incur expenses during the plan year, submit a receipt copy and/or a copy of the Explanation of Benefits (EOB), if applicable, with your MONEYPLU$ claim form for reimbursement through your MONEYPLU$ Spending Account.
- You may only submit a MONEYPLU$ claim form for reimbursement through your MONEYPLU$ Spending Account for the actual out-of-pocket expenses covered. Once FBMC receives your claim, your reimbursement request will be processed within five business days. For Dependent Care Spending Accounts, checks are prepared up to the amount of your current account balance. Any excess dependent care expenses will be held in suspense and dispersed when money is available in your account.
- You will be reimbursed for your eligible expenses through your MONEYPLU$ Spending Account until you have exhausted your annual fund contributions or until the plan year ends.
- Funds remaining in your MONEYPLU$ Spending Accounts after March 31 of the following year cannot be refunded or rolled over to the next plan year.

What documentation of expenses do I need to keep?

The IRS **requires** MONEYPLU$ Spending and Health Savings Account customers to maintain complete documentation, including keeping copies of receipts for reimbursed expenses.

Spending Account Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of Spending Account. Refer to the "Written Certification" portion of the *Beyond Your Benefits* section of this Reference Guide for more specifics.
2. You cannot transfer money between Spending Accounts or pay a dependent care expense from your Medical Spending Account or vice versa.
3. You have a 90-day grace period (until March 31, 2006) at the end of the plan year for reimbursement of eligible Spending Account expenses incurred during your period of coverage within the 2005 Plan Year.
4. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your Spending Accounts.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service which you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the 2005 Plan Year. IRS regulations state that any unused funds which remain in your Spending Account after a plan year ends and all reimbursable requests have been submitted and processed cannot be returned to you nor carried forward to the next plan year.

Will contributions affect my income taxes?

Salary reductions made under a cafeteria plan, including contributions to an HSA or to one or both Spending Accounts, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting a MONEYPLU$ Health Savings or Spending Account. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

What fees must I pay for MONEYPLU$?

There is a $2.50 administrative monthly fee for each spending account and a $0.12 fee for Pretax Group Insurance Premium feature. For example, if you choose to participate in the Medical and Dependent Care Spending Accounts, you will pay $5.00 each month in administrative fees. All fees are deducted from pre-tax dollars. Fees for the Health Savings Account are explained on Page 8.

Get More Information

For additional information regarding MONEYPLU$, refer to your *Insurance Benefits Guide,* which is available from your benefits administrator. You may also access MONEYPLU$ information on the Employee Insurance Program Web site at **www.eip.sc.gov**.

How much money will I save?

The following example shows how paying for benefits with pre-tax dollars saves you money and increases your spendable income.

	Without MONEYPLU$	With MONEYPLU$
Gross Monthly Pay	$2,500.00	**$2,500.00**
State Retirement	-150.00	**-150.00**
Pretax Payroll Deduction*	-0.00	**-613.00**
Administrative Fee	-0.00	**-5.12**
Taxable Gross Income	$2,350.00	**$1,731.88**
Payroll Taxes	-530.00	**-314.11**
After-tax Expenses*	-613.00	**-0.00**
Spendable Income	$1,207.00	**$1,417.77**

Increase in Spendable Income: $210.77

* For the purpose of this example only, monthly pre-tax payroll deductions and after-tax expenses are defined as the following:

Health Premium	$159
Dental Premium	$ 21
Dependent Care Expenses	$400
Out-of-Pocket Medical Expenses	$ 33
Total	$613

Spendable income is considered the amount of your paycheck, plus the reimbursement from your MONEYPLU$ Medical and/or Dependent Care Spending Accounts.

New! MONEYPLU$ Health Savings Accounts

What is a Health Savings Account?

Providing economical health care in the face of rising costs is a major issue facing the nation. In 2005, as part of an effort to cope with this challenge, the Employee Insurance Program (EIP) will begin offering a State Health Plan Savings Plan coupled with a Health Savings Account (HSA). This option will enable subscribers who are willing to take greater responsibility for their medical care the opportunity to reduce their insurance premiums and save money for major medical expenses.

A Health Savings Account (HSA) is a tax-free account that can be used to pay health care expenses. Unlike money in a MONEYPLU$ Medical Spending Account, the funds do not have to be spent in the plan year they are deposited. Money in the account, including interest, accumulates tax-free, so the funds can be used to pay qualified medical expenses in the future. An important advantage of an HSA is that it is owned by the employee. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

Who is eligible to contribute to a MONEYPLU$ HSA?

- Employees must be covered by the State Health Plan Savings Plan, available January 1, 2005.
- Employees cannot be covered by any other health plan, including Medicare. However, they may be covered for specific injuries, accidents, disability, dental care, vision care and long-term care.
- Participants cannot be claimed as a dependent on another person's tax return.

How much may I contribute to my HSA?

If you enroll in the MONEYPLU$ HSA your contributions are deducted on a pre-tax basis. In 2004, a subscriber with single coverage could contribute up to $2,600 a year to an HSA. Those covering more than one family member could contribute up to $5,150 a year. These limits, established by the federal government and subject to change, are tied to the rate of inflation. The maximum monthly contribution is calculated based on the annual allowable amount and number of months remaining in the contribution year. A subscriber age 55 and older may make "catch-up" contributions to an HSA. In 2005, that subscriber can contribute $600 above the limit.

You may also make after-tax contributions, which apply toward the maximum annual limit(s). You will receive additional information when you enroll.

How can I change my HSA contribution amount?

You may change the amount you contribute to your MONEYPLU$ HSA once per quarter. To make a change to your HSA contribution amount, contact your benefits administrator.

How do I get funds out of my HSA?

After enrolling in the HSA and completing a Bank Signature Card form, your contributions will be sent to the custodian, National Bank of South Carolina (NBSC), an affiliate of Synovus Financial Corp. NBSC will establish an individual account for you and mail you up to two VISA® debit cards to your home address at no charge. You may order additional cards or a small supply of checks by contacting NBSC at **1-877-367-4HSA** (472). You may use the debit card or checks to get funds out of your HSA. Remember, as long as you are taking funds out for qualified medical expenses, there are no taxable consequences to you; however, if you withdraw funds for ineligible expenses, you may experience taxable consequences and penalties on the receipt of such funds unless you reimburse your HSA for the ineligible amount.

Will I be charged any banking or custodian fees?

Yes. NBSC will charge you $2 per month for your HSA. If you prefer to pay a $20 annual fee, instead, you may contact NBSC within 60 days of account opening. This fee includes the VISA debit card, all transaction fees associated with the card, a supply of checks, monthly statements and other banking services. There is a $.50 charge to process each check you write to get funds from your HSA. NBSC will deduct these fees automatically from your HSA. Other fees may apply including fees for insufficient funds. Refer to your HSA Disclosure Statement for more information.

Are my HSA funds invested?

Your funds will initially be held in an interest-bearing checking account at NBSC. The bank can provide you with applicable interest rates for HSAs since these rates are subject to change from time-to-time. As your account balance grows, you may be eligible to invest your funds in other types of investments. NBSC will communicate these investment and brokerage opportunities when applicable.

Are there any special tax forms or tax-reporting that I must complete when filing my income taxes at year-end?

NBSC will send your tax filing information, after the end of the taxable year, for your use in reporting your contributions to your HSA and to report any withdrawals or distributions from your HSA. It is important that you save receipts, invoices and any explanations of benefits received from your health insurance carrier as documentation, in case you are ever asked to show proof of qualified medical expenses to the IRS.

What if I exceed the annual contribution limits established by the IRS?

FBMC will monitor your HSA contributions and send an alert to your benefits administrator and advise that you are exceeding your contribution limits. NBSC will also send courtesy notices periodically reminding you to check your account balance and ensure that you are not exceeding the allowable annual contribution limits. You may decrease or stop your contributions accordingly, but the best way to ensure that you do not exceed the annual contribution limits is to elect a per-pay-period contribution that ensures you will not exceed the annual limits ($2,600 for single coverage and $5,150 for family coverage). Of course, you can add the "catch-up" contribution amount to these annual limits if you are age 55 or older. The catch-up contribution for 2005 is $600.

May I have a MONEYPLU$ HSA and Spending Account?

Yes, subscribers may enroll in a MONEYPLU$ limited-use Medical Spending Account to pay certain eligible expenses. The limited-use Medical Spending Account may be used to pay expenses not covered by the Savings Plan, including dental and vision care expenses. MONEYPLU$ Dependent Care Spending Account eligibility is not affected by your HSA participation. See Page 12 for more information.

Flyers will be available with your enrollment information. Information is also available by contacting FBMC at 1-800-342-8017 or by e-mail at **webcustomerservice@fbmc-benefits.com**.

Remember, MONEYPLU$ limited-use Medical Spending Accounts are available only to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation.

PreTax Group Premium Feature

PreTax Group Insurance Premium Feature

With this feature, you can pay your State Health Plan, HMO, State Dental Plan, Dental Plus and Optional Life (for coverage up to $50,000) premiums before taxes are taken out of your paycheck. This feature is suitable for all employees since you do not have to pay taxes on the dollars you use to pay these premiums. You are enrolled automatically in this feature on the NOE if you pay a health, dental or Optional Life premium, unless you decline. There are special enrollment procedures if you want to participate in the spending accounts. Contact your benefits administrator for details.

If you declined the PreTax Group Insurance Premium Feature in the past, you can enroll during the announced enrollment period for an effective date of January 1 of the following year. The monthly administrative fee for deducting medical, dental and optional life premiums before taxes is $0.12, which is deducted from your paycheck before taxes are deducted.

Optional Life Insurance Premiums

You can pay your Optional Life insurance premiums before you pay taxes. Your entire Optional Life insurance premium will be deducted from your check before taxes. However, only premiums for coverage up to $50,000 will be exempt from tax. Premiums paid for additional coverage amounts (more than $50,000) will be added back to your earnings on your W-2 form at the end of the year.

Minimum Annual Deposit*: **None**
Maximum Annual Deposit*: **$5,000**

* Including administrative fees

What is a Medical Spending Account?

A Medical Spending Account is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

Your Medical Spending Account may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse and
- your tax dependents.

To qualify as your tax dependent, an individual must:

- be your relative, or
- live with you for the entire calendar year if not your relative.
  In either case, the individual must also be:
  - a U.S. citizen or a resident of the U.S., Mexico or Canada and
  - the recipient of at least half of their total support and/or expenses during the calendar year from you.

An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Spending Account.

When are my funds available?

Once you sign up for a Medical Spending Account and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay eligible health care expenses at the start of the plan year.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Medical Spending Account reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires that the complete name of all medicines and drugs be obtained and documented on pharmacy receipts. This information must be included when submitting your request to FBMC for reimbursement.

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Note: Budget conservatively. No reimbursement or refund of Medical Spending Account funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Can travel expenses for medical care be reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Medical Spending Account. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- parking fees
- tolls and
- transportation to another city.

MONEYPLU$ Medical Spending Accounts

CONTINUED

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable if the proper documentation is attached to the initial FSA Reimbursement Request Form each plan year:

- a written statement from the treating dentist/orthodontist showing the type and date the service incurred, the name of the eligible individual receiving the service and the cost for the service
- a Letter of Medical Need from the treating dentist/orthodontist and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call FBMC Customer Service at 1-800-342-8017.

Should I claim my expenses on IRS Form 1040?

With a Medical Spending Account, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax free, regardless of the amount. By enrolling in a Medical Spending Account, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on their percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Medical Spending Account include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

When do I request reimbursement?

You may use your Medical Spending Account to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How do I request reimbursement?

Requesting reimbursement from your Medical Spending Account is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with the following:

- a receipt, invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost or
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the receipt, invoice or bill for the service.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Visit www.fbmc-benefits.com for a list of frequently asked questions.

You must keep your receipts for a minimum of one year and submit to FBMC upon request.

May I have a MONEYPLU$ Spending Account and Health Savings Account?

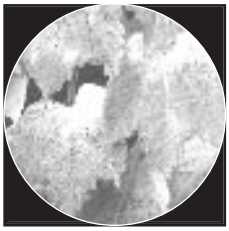
Yes, MONEYPLU$ HSA subscribers may enroll in a MONEYPLU$ limited-use Medical Spending Account to pay certain eligible expenses. The limited-use Medical Spending Account may be used to pay expenses not covered by the SHP Savings Plan, including dental and vision care expenses. Except for the restriction on what kinds of expenses are reimbursable, a MONEYPLU$ limited-use Medical Spending Account works the same as a MONEYPLU$ Medical Spending Account.

Since you can pay for your out-of-pocket medical expenses with your MONEYPLU$ HSA, some MONEYPLU$ Medical Spending Account features are not available with a MONEYPLU$ limited-use Medical Spending Account, including:

- no reimbursement of out-of-pocket medical expenses, such as deductibles, coinsurance and co-payments
- no reimbursement for Over-the-Counter items and
- no EZ REIMBURSE® Card reimbursement option.

Remember, MONEYPLU$ limited-use Medical Spending Accounts are available only to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation.

For additional information regarding MONEYPLU$, refer to your Insurance Benefits Guide, which is available from your benefits administrator. You may also access MONEYPLU$ information on the Employee Insurance Program Web site at www.eip.sc.gov.



Basics about the EZ REIMBURSE® Card

The EZ REIMBURSE® Card debits funds electronically from your MONEYPLU$ Medical Spending Account when an eligible, uninsured medical expense is incurred.*

There is no risk of overspending or exceeding your account limits. If funds are not available because your annualized amount has been spent down, the transaction is denied. Because no credit is being extended, EZ REIMBURSE® Cards are available to anyone who signs up for a Medical Spending Account.

About 50 percent of all Medical Spending Account claims are for prescription drugs. FBMC and its partners developed a system enabling online, real-time adjudication of prescription drug claims. When you present the EZ REIMBURSE® Card at ***participating pharmacies*** to buy a prescription drug or to pay the prescription co-payment, your Spending Account is automatically debited. You also avoid the double-hit to your wallet while waiting for reimbursement.

You may use the EZ REIMBURSE® Card for:

- co-payments at doctor/dentist/ophthalmologist/optometrist offices
- deductibles
- prescription co-payments or
- uncovered prescriptions and other health-related expenses.

IRS guidance reduces the need for submitting documentation to FBMC for eligible prescription expenses and co-payments. For all other health care expenses, you must send or fax a copy of your statement, bill or receipt (showing date of service, type of service and total amount) along with an EZ REIMBURSE® Card Transmittal Sheet for processing. However, you **must** keep all substantiating documents for your records for a minimum of one year and submit immediately to FBMC or the IRS upon request. You do not have to wait for reimbursement; as long as the vendor accepts MasterCard® and is appropriately coded as a health care facility, the expense is still debited from your Spending Account... and not from your wallet! Instructions on when to submit receipts will be provided to card participants in Monthly Statements.

To view a list of participating pharmacies before January 1, 2005, who accept the EZ REIMBURSE® Card, visit the EIP Web site: www.eip.sc.gov

To view a list of participating pharmacies after January 1, 2005, who accept the EZ REIMBURSE® Card, visit: www.fbmc-benefits.com

Remember, you must keep your receipts for a minimum of one year and submit to FBMC upon request.

* **The EZ REIMBURSE® Card is not available to MONEYPLU$ limited-use Medical Spending Account participants.** Please see the *Beyond Your Benefits* section of this Tax-Favored Accounts Guide for information about debit card reimbursement.

What are the advantages of the EZ REIMBURSE® Card?

- Instant reimbursements – cash-free transactions!
- Paperless prescription medication purchases – instant claims adjudication
- Tax savings by participating in a Medical Spending Account

How do I get an EZ REIMBURSE® Card?

When you sign up for a Medical Spending Account, you must elect to receive your EZ REIMBURSE® Card on your Enrollment Form. It comes to you in the mail just like a regular credit card; you call the toll-free number on the front to activate the card. For additional information regarding the EZ REIMBURSE® Card, call FBMC Customer Service at 1-800-342-8017, Monday through Friday, 7 a.m. - 10 p.m. ET.

What agreement am I making when I use the EZ REIMBURSE® MasterCard®?

By using the EZ REIMBURSE® Card, you are agreeing to the certification set out in the "Written Certification" portion of the *Beyond Your Benefits* section of this Tax-Favored Accounts Guide.

What does it cost to use the EZ REIMBURSE® Card?

There is a $20 non-refundable, annual fee for using the card. This amount is automatically deducted from your Medical Spending Account. When you budget for your Spending Account deductions, be sure to consider the fee in your calculations.

When do I use paper claim forms?

If a merchant or vendor does not accept the EZ REIMBURSE® Card, you must submit a paper claim form. For example, you cannot use your card for Over-the-Counter expenses and for mail-order prescriptions. You will need to submit an FSA Reimbursement Request Form, attach a copy of your documentation and wait for the reimbursement. To speed up your reimbursement, you can sign up for direct deposit.

What should I do if my pharmacist doesn't know how to use the card?

For questions or assistance, your provider/pharmacist may contact the Pharmacy Help Desk at 1-800-361-4542 (M - F, 8 a.m. - 7 p.m.; Sat., 9 a.m. - 5 p.m.; Sun., 12 p.m. - 5 p.m. ET).

What do I do if I lose my card?

If your card is lost or stolen, call 1-866-785-3621 immediately.

Where can I get more information?

For a list of frequently asked questions, visit **www.fbmc-benefits.com**. Additional information is also available by contacting FBMC Customer Service by e-mail at **webcustomerservice@fbmc-benefits.com**, or by calling 1-800-342-8017.

The EZ REIMBURSE® MasterCard® Card is issued by BANKFIRST.

OTC Category Reimbursement

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may now be reimbursable through your Medical Spending Account! Save valuable tax dollars on certain categories of OTC items, medicines and drugs. You may be reimbursed for OTCs through your Medical Spending Account if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your employer's MONEYPLU$ Medical Spending Account plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner.

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at **www.fbmc-benefits.com**. As soon as an OTC item, medicine or drug becomes eligible under any of the categories below, it will be reimbursable retroactively to the start of the then current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Medical Spending Account election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Eligible Expense Categories

Allergy
Antihistamines
Nasal sprays

Antacids
Heartburn medicines

Cold Remedies
Cough drops
Decongestants
Nasal strips
Nasal sprays
Sinus medications
Throat lozenges

Pain Relief
Bug bite medication
Fever reducers
First aid creams (diaper, fever blister, poison ivy)
Menstrual cycle products for pain and cramp relief
Products for muscle or joint pain
Special ointments or creams for sunburn
Topical creams

Other Medical Remedy Items
Anti-diarrheals
Anti-fungals
Antibiotics
Asthma medications
Bandages, gauze pads, rubbing alcohol, liquid adhesives
Carpal tunnel wrist supports
Cold/hot packs for injuries
Corn/callus removers
Eye products (including reading glasses, contact lens cleaning solutions)
First aid kits
Hemorrhoid treatments
Laxatives
Motion sickness treatments
Nicotine gum or patches for smoking cessation purposes
Thermometers
Wart removers

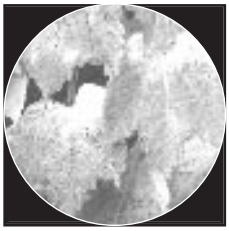
Items Requiring Special Documentation*

Botanicals/herbals
Feminine hygiene products
Hormones
Minerals
Nasal sprays for snoring
Sunscreens
Vitamins
Weight-loss drugs to treat a specific disease

Ineligible OTC Expenses

Cosmetics
Toiletries
OTC items primarily for general health and well-being

* Contact FBMC Customer Service at **webcustomerservice@fbmc-benefits.com** or call FBMC Customer Service at 1-800-342-8017 for more information or to obtain a sample Letter of Medical Need or Personal Use/Capital Expenditures Statement.



Note: The EZ REIMBURSE® MasterCard® Card cannot be used for Over-the-Counter expenses.

Minimum Annual Deposit*: None

Maximum Annual Deposit*: The maximum contribution depends on your tax filing status as the list below indicates.

* Including administrative fee

What is a Dependent Care Spending Account?

A Dependent Care Spending Account is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

Under the Dependent Care Spending Account, you may be reimbursed for eligible dependent care expenses incurred by individuals residing in your household for at least eight hours a day including:

- children 12 years or younger and
- adults/children mentally or physically incapable of self-care.

What is my maximum annual deposit?

- If you are married and filing separately, your maximum annual deposit is $2,500.
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care Spending Account and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a **Medical Spending Account, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.**

Partial List of Eligible Expenses*

After school care
Baby-sitting fees
Day care services
In-home care/au pair services
Nursery and preschool
Summer day camps (overnight camps are not eligible)

Note: Budget conservatively. No reimbursement or refund of Dependent Care Spending Account funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care Spending Account is always tax free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care Spending Account may produce a greater tax benefit than claiming tax credits or exclusions alone.

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care Spending Account cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information. You may also visit **www.fbmc-benefits.com** to complete a Tax Savings Analysis.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care Spending Account include:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

CONTINUED

Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You can request reimbursement from your Dependent Care Spending Account as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care Spending Account. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or direct deposit promptly.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care Spending Account is easy. Simply mail or fax a correctly completed Flexible Spending Account Reimbursement Request Form along with receipts showing the following:

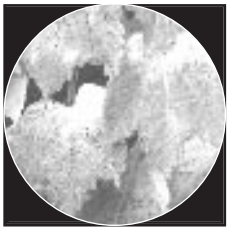
- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care Spending Account. This information is required with each request for reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 850-425-4608

Note: If you elect to participate in the Dependent Care Spending Account, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.



MONEYPLU$ Spending Account Worksheets

To figure out how much to deposit in your Spending Account, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount (including the administrative fees) cannot exceed established IRS and plan limits. (Refer to the individual Spending Account descriptions in this Tax-Favored Accounts Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

MEDICAL SPENDING ACCOUNT WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____
SUBTOTAL	$ _____
ADD annual $2.50 administration fee.	$ _____
EZ REIMBURSE® MasterCard® Card annual, non-refundable $20 fee	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	$ _____
This is your per-pay-period contribution.	$ _____

* If you are retiring or are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year. To participate in the **Medical Spending Account**, you must have completed one year of continuous state service by January 1 following an enrollment period. See Page 5 for details.

DEPENDENT CARE SPENDING ACCOUNT WORKSHEET

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Day care services	$ _____
In-home care/au pair services	$ _____
Nursery and preschool	$ _____
After school care	$ _____
Summer day camps	$ _____

ELDER CARE SERVICES

Day care center	$ _____
In-home care	$ _____
SUBTOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year (including administrative fee).	$ _____
ADD annual $2.50 administration fee.	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	$ _____
This is your per-pay-period contribution.	$ _____

* If you are retiring or are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

At your request, your Spending Account reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.

Please remember to include all applicable fees to your Medical Spending Account contribution if you plan to use your EZ REIMBURSE® Card as a form of payment.

Changing Your Coverage

THIS INFORMATION APPLIES ONLY TO THE FLEXIBLE SPENDING ACCOUNTS.

Am I permitted to make mid-plan-year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-plan-year election change to your Spending Account election, or vary a salary reduction amount, depending on the qualifying event and requested change.

How do I make a change?

You can change your Spending Account election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. Partial lists of permitted and not permitted qualifying events under your employer's plan(s) appear on the following page. Election changes must be consistent with the event. FBMC will, in its sole discretion, review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within **31 days** of an event that is consistent with one of the events on the following pages, you must complete and submit a Change in Status/Election Form to your benefits administrator. Contact your benefits administrator or visit www.eip.sc.gov to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing Spending Account(s) elections will be stopped or modified (as appropriate). If your MONEYPLU$ Spending Account election change request is denied, you will have **31 days**, from the date you receive the denial, to file an appeal with FBMC. For more information, refer to the "Appeal Process" section on Page 5.

What is my period of coverage?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan-year election change. A mid-plan-year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan-year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the Spending Account prior to the change.

What are the IRS Special Consistency Rules governing Changes in Status?

1. **Loss of Dependent Eligibility–** If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, or annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of Coverage Eligibility Under Another Employer's Plan–** If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses–** You may change or terminate your Dependent Care Spending Account election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

Changes in Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce, annulment or legal separation.
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes:

Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care Spending Account benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Annual Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Annual Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child **and only if the other individual actually provides the coverage.**
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical Spending Account.

† Does not apply to a Dependent Care Spending Account.

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans, including Medical Spending Accounts, give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights. Specific information describing continuation coverage can be found in the Plan's summary plan description, which can be obtained from your employer.

How long will continuation coverage last?

If you fund your Medical Spending Account entirely, you may continue your Medical Spending Account (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the Medical Spending Account for the year. For example, if you elected a maximum Medical Spending Account benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Medical Spending Account for the remainder of the plan year or until such time that you receive the maximum Medical Spending Account benefit of $1,000.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time.

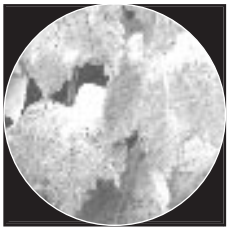
How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 62-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 31 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. For Medical Spending Accounts, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.



When and how must payment for continuation coverage be made?

First Payment For Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage **within 45 days after the date of your election.** (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact FBMC to confirm the correct amount of your first payment.

Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the **first day of each month**. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

How can I get more information?

This *COBRA Q&A* section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description. You can get a copy of your summary plan description from your employer or FBMC.

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and FBMC informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and FBMC.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Customer Service at 1-800-342-8017 for an approximation.

Written Certification

When enrolling in either or both Spending Accounts, written notice of agreement with the following will be required:

- I will only use my Spending Account to pay for IRS-qualified expenses and only for my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my Spending Account
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

Notice of Administrator's Capacity

PLEASE READ: This notice advises Spending Account participants of the identity and relationship between South Carolina Budget & Control Board and its Contract Administrator, Fringe Benefits Management Company (FBMC). FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the Flexible Reimbursement Account plans offered herein. FBMC will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against FBMC than would otherwise be afforded to you by law.

Processing Claims for Debit Card Transactions

The IRS requires all Spending Account expenses be substantiated by an independent third-party review of the required supporting documentation. Recent IRS guidance permits this review to be conducted electronically when certain expenses are paid with a debit card that is used in conjunction with an Spending Account. Generally, this applies to prescriptions, known co-payment amounts and recurring expenses. However, some expenses that fall into any of these categories may still require documentation be submitted for further review. All expenses that fall outside these categories require documentation be submitted to FBMC.

The IRS guidance requires Spending Account customers keep the required documentation for a minimum of one year and submit immediately to FBMC upon request. Any customer who refuses to comply with such request or who uses his/her card for unqualified expenses may experience any or all of the following actions:

- suspension of card privileges
- offset to paper claim reimbursements (automatic substitution)
- tax consequences at the end of the calendar year.

Automatic Substitution for Debit Card Receipts

The IRS requires documentation of all Flexible Spending Account transactions. FBMC will continue notifying you in writing that documentation is needed/required to validate your debit card transactions (e.g. original receipts, substitute receipts, medical needs letter or payments, etc.).

For your convenience, FBMC will apply approved paper claim requests to any outstanding debit card transactions. After receiving and processing approved debit card receipts, a payment will be made to you representing the difference between the approved paper claim(s) and any outstanding debit card transactions (if applicable).

Example: A debit card participant, John, has not submitted receipts for three (3) debit card transactions, each in the amount of $10. Later, John submits a paper reimbursement request form for an eligible, out-of-pocket expense totaling $120 and the entire amount is authorized for reimbursement. John will receive a reimbursement payment of $90. The remaining $30 of the $120 reimbursement request will be used to offset the outstanding debit card transactions. After receiving and processing approved debit card receipts, a payment will be sent to John which represents the difference between the approved paper claim ($120) and the outstanding debit card transactions ($30).

FBMC Privacy Notice 4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:
   - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
   - Responses from you and others such as information relating to your employment and insurance coverage.
   - Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
   - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

   Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.fbmc-benefits.com. You have a right to a paper copy at any time. Contact FBMC Customer Service at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Service 1-800-342-8017 • 1-800-955-8771 (TDD)
www.fbmc-benefits.com

Information contained herein does not constitute an insurance certificate or policy.

FBMC/SSC/0904